Operational Policy Letter #59

Attachments

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Attachment I

HEDIS® 3.0/98 Domains/Measures by Category of Reporting for Summary Data

ALL PLANS TO REPORT BY LEGAL ENTITY:

Health Plan Stability:

- Indicators of Financial Stability

ALL PLANS TO REPORT BY CONTRACT:

Cost of Care

- High-Occurence/High-Cost DRGs
- Rate Trends

Health Plan Descriptive Information

- Provider Compensation

CONTRACT REPORTING CATEGORY TO REPORT BY CONTRACT; MARKET AREA REPORTING CATEGORY TO REPORT BY MARKET AREA

Effectiveness of Care

- Breast Cancer Screening
- Beta Blocker Treatment After a Heart Attack
- Eye Exams for People with Diabetes

- Follow-up After Hospitalization for Mental Illness
- The Health of Seniors

Access to/Availability of Care

- Adults' Access to Prevention/Ambulatory Health Services
- Availability of Primary Care Providers
- Availability of Mental Health/Chemical Dependency Providers
- Availability of Language Interpretation Services, Parts I & II

Health Plan Stability

- Years in Business/Total Membership
- Disenrollment
- Provider Turnover

Use of Services

- Frequency of Selected Procedures
- Inpatient Utilizatin - General Hospital/Acute Care
- Ambulatory Care
- Inpatient Utilization - Non-Acute Care
- Mental Health Utilization - Inpatient Discharges and Average Length of Stay
- Mental Health Utilization - Percentage of Members Receiving Inpatient, Day/Night and Ambulatory Services
- Readmission for Specified Mental Health Disorders
- Chemical Dependency Utilization - Inpatient Dishcarges and Average Length of Stay
- Chemical Dependency Utilization - Percentage of Memebers Receiving Inpatient, Day/Night and Ambulatory Services
- Readmission for Chemical Dependency
- Outpatient Drug Utilization (for those with a Drug Benefit)

Health Plan Descriptive Information

- Board Certification/Residency Completion
- Total Enrollment
- Enrollment by Payor (Member Years/Months)

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Attachment II-1

Measures Which Require Patient-Level Identifiers

Plans must provide the patient identifier, or HIC number, for all beneficiaries included in the summary data. The HIC number is assigned by HCFA to the beneficiary when he/she signs up for Medicare, and health plans use this number for accretions/deletions. In addition to the patient identifier, plans also must provide the member month contribution for each beneficiary and indicate how each beneficiary contributed to the calculation of the following summary measures.

The list below includes five new Use-of-Services measures: Inpatient Utilization - General Hospital/Acute Care, Inpatient Utilization - Nonacute Care; Ambulatory Care; Mental Health Utilization - Inpatient Discharges and Average Length of Stay; and Chemical Dependency Utilization - Inpatient Discharges and Average Length of Stay. Attachment II-2 demonstrates the type of information required for each measure.

Effectiveness of Care

- Breast Cancer Screening
- Beta Blocker Treatment After a Heart Attack
- Eye Exams for People with Diabetes
- Follow-up After Hospitalization for Mental Illness

Use of Services

- Frequency of Selected Procedures
- Inpatient Utilization - General Hospital/Acute Care
- Ambulatory Care
- Inpatient Utlization - Non-Acute Care
- Mental Health Utilization - Inpatient Dishcarges and Average Length of Stay
- Mental Health Utilization - Percentage of Members Receiving Inpatient, Day/Night and Ambulatory Services
- Readmission for Specified Mental Health Disorders
- Chemical Dependency Utilization - Inpatient Dishcarges and Average Lenggth of Stay
- Chemical Dependency Utilization - Percentage of Members Receiving Inpatient, Day/Night and Ambulatory Services
- Readmission for Chemical Dependency

To be useful, this patient-level data must match the summary data for the measures discussed here, *i.e.* the patient file should contain all beneficiaries enrolled in the plan at the time that the summary measures are calculated. To ensure an exact match, the plan should make a copy, or "freeze," its database when the summary measures are calculated. NCQA will provide plans with exact file specifications in sufficient time to allow plans to identify the best way to fulfill this requirement.

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Attachment II-2

Description of Patient-Level Information

This attachment describes the type of patient-level information required for each measure. These charts are only meant to communicate the type of information HCFA requires. NCQA will provide plans with exact format specifications for submitting data.

The following examples use a fictional plan of 100 members, including beneficiaries HIC1, HIC2, HIC3, and HIC100, to depict the required information. For each plan member, the plan must provide three important pieces of information.

- HIC Number (Patient Identifier)
- Member Month Contribution
- Each Member's Contribution (or lack thereof) to Each Measure

This implies that information should be provided on **every** plan member for **every** measure, even if the beneficiary did not contribute to a specific measure. For example, for Breast Cancer Screening, the plan would indicate "no" for male members for both the denominator and numerator.

Ultimately, plans will submit data in numeric form, such as a 1 for yes and a 0 for no. However, the examples below use text in order to better communicate the desired information. NCQA will provide plans with final file specifications in time for them to adequately extract the required data.

The charts below demonstrate how beneficiaries HIC1, HIC2, HIC3, and HIC100 would appear in a database. For example, HIC1 has a member month contribution of 12 months, was counted in the denominator for breast cancer screening, and received some ambulatory mental health care and several other ambulatory services.

Please consult the HEDIS Technical Specifications for a complete description of each measure.

1. **Member Month Contribution**

   Plans must provider the member month contribution for each HIC number.

HIC	Member Month

Number	Contribution
HIC 1	12
HIC 2	12
HIC 3	8
...	...
HIC 100	10

2. **Effectiveness of Care Measures**

   Plans will need to provide numerator and denominator information for the Beta Blocker and Eye Exam Effectiveness of Care measures similar to the Breast Cancer Screening example below. For the Follow-up After Hospitalization for Mental Illness measure, plans should report the total number of valid discharges and follow-ups for each beneficiary. (Please see the HEDIS Technical Specifications to determine which discharges and follow-ups should be counted.)

HIC Number	Denominator Breast Cancer Screening	Numerator Breast Cancer Screening	Denominator Follow-up after Mental Illness	Numerator Follow-up after Mental Illness
HIC 1	Yes	No	2	1
HIC 2	Yes	Yes	0	0
HIC 3	No	No	0	0
...	...	...	...	...
HIC 100	No	No	1	1

3. **Use of Services - Frequency of Selected Procedures**

   Plans must provide the same numerator information for all the procedures listed under the Frequency of Selected Procedures Measure. Plans should report the total number of times a beneficiary received each procedure.

HIC Number	Numerator Frequency of Selected Procedures - CABG	Numerator Frequency of Selected Procedures - Total Knee Replacement
HIC 1	0	0
HIC 2	1	2
HIC 3	0	0
...	...	...
HIC 100	0	0

4. **Use of Services - Inpatient Utilization - General Hospital/Acute Care**

   Plans must report the total number of discharges and associated days for each beneficiary for each category. Note that HIC3 had 2 surgery discharges with a total of 12 associated days. Hypothetically, the first hospitalization may have lasted 4 days and the second may have lasted 8 days. Similarly, HIC3 also had 2 medical hospitalizations in the reporting year with a total of 4 associated days. Note that the total discharges (4) and days (16) for HIC3 is the sum of the discharges and days from the other three categories: surgery, medicine, and maternity.

HIC Number	Denominator Discharges - Total	Numerator Days - Total	Denominator Discharges - Surgery	Numerator Days - Surgery
HIC 1	0	0	0	0
HIC 2	2	8	1	5
HIC 3	4	16	2	12
...	...	...	...	...
HIC 100	0	0	0	0

...continuation of Inpatient Utilization - General Hospital/Acute Care

HIC Number	Denominator Discharges - Medicine	Numerator Days - Medicine	Denominator Discharges - Maternity	Numerator Days - Maternity
HIC 1	0	0	0	0
HIC 2	1	3	0	0
HIC 3	2	4	0	0
...	...	...	...	...
HIC 100	0	0	0	0

5. **Use of Services - Ambulatory Care**

   Plans must provide the total number of visites or stays for each beneficiary in each category.

HIC Number	Numerator Outpatient Visits	Numerator Emergency Room Visits	Numerator Ambulatory/ Surgery Procedures	Numerator Observation Room Stays Resulting in Discharge
HIC 1	4	1	2	0

HIC 2	0	0	0	0
HIC 3	2	1	0	0
...	...	...	...	...
HIC 100	6	0	1	1

6. **Use of Services - Inpatient Utilization - Nonacute Care**

   Plans must provide the total number of discharges and associated days for each beneficiary. Again, the number of reported days should be the total number of days associated with each discharge. For example, HIC3 might have had 10 days associated with each of his 3 discharges, for a total of 30 days.

HIC Number	Numerator Nonacute Discharges	Numerator Nonacute Days
HIC 1	0	0
HIC 2	1	17
HIC 3	3	30
...	...	...
HIC 100	0	0

7. **Use of Services - Mental Health Utilization and Chemical Dependency Utilization - Inpatient Dishcarges and Average Length of Stay**

   Plans must provide the total number of discharges and associated days for each beneficiary. Again, reported days should be the total number of days associated with the reported discharges. Like the Mental Health Utilization example below, plans must report inpatient discharges and days for Chemical Dependency Utilization.

HIC Number	Numerator MH Inpatient Discharges	Numerator MH Inpatient Days
HIC 1	0	0
HIC 2	0	0
HIC 3	1	8
...	...	...
HIC 100	2	14

8. **Use of Services - Mental Health Utilization and Chemical Dependency Utilization - Percentage of Members Receiving Inpatient, Day/Night Care and Ambulatory Care**

   Like the Mental Health Utilization example below, plans must indicate both whether a member had any Chemical Dependency Utilization and, if so, where they received that care: inpatient, day/night, or ambulatory. For both the Mental Health and Chemical Dependency Utilization measures, if any equals "yes" then at least one of the three numerator columns (inpatient, day/night, ambulatory) should have a value of "yes."

HIC Number	Numerator Mental Health Utilization - Any	Numerator Mental Health Utilization - Inpatient	Numerator Mental Health Utilization - Day/Night	Numerator Mental Health Utilization - Ambulatory
HIC 1	Yes	No	No	Yes
HIC 2	Yes	No	Yes	No
HIC 3	No	No	No	No
...	...	...	...	...
HIC 100	No	No	No	No

9. **Use of Services - Mental Health Readmission and Chemical Dependency Readmission**

   Like the Mental Health Readmission measure below, plans must indicate which members contribute to the denominator of the Chemical Dependency Readmission measure and to the numerator for Chemical Dependency Readmissions at 90 days and 365 days.

HIC Number	Denominator Readmission for MH Disorders	Denominator Readmission for MH Disorders - 90 Days	Denominator Readmission for MH Disorders - 365 Days
HIC 1	No	No	No
HIC 2	Yes	Yes	Yes
HIC 3	No	No	No
...	...	...	...
HIC 100	Yes	No	Yes

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Attachment III

Questions and Answers

HEDIS® 3.0/98:

1. **How will HCFA release data for HEDIS® 3.0/98?**

   No patient level data will be released. Patient level data is protected in accordance with the Privacy Act of 1974 (The entire Privacy Act, Title 5, U.S.C., Sec.552.a will apply). This data will not be made public. The data will be used by HCFA and its representatives for research purposes and plan monitoring.

   HCFA will release the summary data following validation. At that point, the data will be public. There will be nothing to preclude NCQA and others from using it in a variet of formats. It will be available to the public in such formats as the Internet, pringed materials, and CD ROM. ICAs (Information, Counseling, and Assistance) of state offices of aging and other advocacy organizations will assist in reaching the beneficiary population.

HEALTH OF SENIORS:

1. **Will the health plans have access to the members' data before 2000, as this could be key in quality improvement efforts?**

   Health of Seniors data will be plan-specific and in aggregate form (i.e., no patient-level information will be provided.) Aggregate data will be provided after the 24 month follow-up survey in 2000. It has not yet been decided whether aggregate data will be provided after the first baseline survey in 1998. As part of a contract with NCQA, NCQA will convene a Health of Seniors technical expert panel which will suggest an approach for the release of aggregate data.

2. **Do we have an estimate of the range of cost for the Health of Seniors survey?**

   Yes. The anticipated range is □ - □ per completed survey.

3. **Can you clarify the 1,000 cohort drawn for the Health of Seniors survey? In year two (1999) of the evalluation, will additional sampling be drawn if less than 1,000 enrollees can be contacted? And, will this occur again in 2000? When will the next cohort of 1,000 enrollees be drawn? In other words, will Health of Seniors reports come out each year after 2000, (e.g., requiring a new cohort be drawn in 1999 for reporting in 2001)? Due to the cost per survey, this is a particular budget issue for plans which may expect to pay for more than 1,000 surveys per year depending on the reporting schedule.**

   The diagram below indicates the current sampling strategy for the Health of Seniors measure. Replacement of the 1,000 persons surveyed at baseline will not be necessary, as the 24 month follow-up does not anticipate a 1000% response rate (the goal is at least 70%). It is anticipated that an entirely new cohort will be drawn every year so that the measure may be reported annually.

1998	1999	2000	2001
Baseline	Baseline	24 Month Follow-up	24 Month Follow-up
Cohort I - 1000	Cohort II - 1000	Cohort I	Cohort II
		New sample of 1,000 drawn for Cohort III	New sample of 1,000 drawn for Cohort IV

   Since the technical expert panel will review the proposed specifications for the measure, this could change.

4. **How will enrollee mortality be handled in reporting the results of the SF-36?**

   Beneficiaries who die between the baseline survey and 24 month follow-up are categorized in "worse" condition for reporting purposes.

5. **Will HCFA risk adjust in its survey?**

   If approved by the technical expert panel, we anticipate that the Health of Seniors measure will be risk adjusted for age, race, gender, social support, co-morbid conditions, and normal expected decline in health status based upon age.